**Staff Injury Prevention within Mental Health Addiction and Intellectual Disability (MHAID) Services**
**Updated January 2019**

**Report prepared for:** Commissioner, Southern District Health Board
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***Executive summary***

A significant programme of work has been underway since 2015 specifically focusing on eliminating injuries to staff as a result of patient distress/aggression as MHAID noted an increasing trend in the numbers of staff injuries. This work was formalised in 2016 when a joint union/MHAID steering group was formed, NZNO have been active participants throughout but unfortunately PSA have never been able to attend.

Alongside of this a weekly/fortnightly (depending on need) meeting looks at all staff injuries in detail and some 'near misses' to identify in a timely manner strategies that could be utilised to prevent reoccurrence. Factors assessed are the physical environment, staffing resources, the patient care planning and the nurse's care and ongoing support needs. This process is undertaken by the CNSs and is separate to the line manager's investigation into the incident.

Data is continually being looked at - analysed to identify relationships between acuity, occupancy, staffing, verbal aggression, complaints etc. Reducing aggression within services will also decrease patient injuries and incidents overall. The **Safety for All** concept underpins many other activities in MHAID

- zero seclusion (3,4)
- safewards model of care including safety huddles and walkabout (RTC infromed) (2)
- SPEC (de-escalation and restraint) (2,4, 10)
- increased use of NRT to minimise nicotine withdrawal (9)
- focusing on assessment period prior to admission (ED, Police),use of sensory modulation activities and education around trauma informed care (TIC) (8,12)
- risk assessment and management tools and education (2,7)
- Increasing nursing leadership and staff numbers after hours (13,15)

There are many more projects that are linked but these are the main ones.
The areas we have been unable to progress are the use of security to support inapti4nt units on the Wakari site and the changes required to physical environments to support MOC changes (p.12)
The 2019 update is attached to provide more detail on the specific activities.

**No staff injury is the MHAIDs ultimate goal.** This goal continues to drive our work to eliminate staff injuries. This work has been ongoing over many years and this paper updates in italics a report that was initially developed in 2016 and has guided the direction of the work in MHAID to reach the goal of no staff injuries.

Incident reporting processes – all incidents are investigated by charge nurse managers as per organisational wide Safety 1st processes.

Due to the increasing concern at the number and extent of staff injuries occurring particularly within the inpatient MHAID services, the following activities have been undertaken and continue to progress to minimise the potential for or eliminate staff being injured as a result of patient aggression.

1. A weekly meeting is established involving clinical nurse specialists/Occupational Health and Safety to investigate circumstances and support injured staff. The aim of this in depth exploration is to prevent staff injuries occurring and to ensure that staff who were injured were supported in an ongoing way. The injury incident review focuses on patient care prior and surrounding the incident, the physical environment, the resources available, the staff actions and training and education needs to identify anything that could have been done differently to prevent injury occurring.

*January 2018 update. On-going – the function of this group and ToR have been reviewed to ensure meeting is making a difference. Meeting now occurs two weekly as opposed to weekly due to decrease in staff injuries. If need arises for weekly meetings in terms of timeliness of response then frequency will be increased.*
***January 2019 update. Ongoing. Meeting frequency changes to meet needs. Constantly reviewing effectiveness of this meeting however continue on as timeliness and comprehensive review of each situation is helpful in preventing further incidents and identifying learnings.***

1. A resource to provide information for staff on workplace aggression was released in 2014

*January 2018 update. This is reviewed and updated as new research/resources become available.*
***January 2019 update. As above. It is helpful having an occupational health and safety representative as part of the weekly/fortnightly group due to their knowledge of changes to legislation and resources.***

2. The Safewards model was formally launched in November 2015 but Safeward interventions commenced in 2014. The focus of the Safewards model is safer wards for patient and staff.

*January 2018 update. Rollout of interventions continues, currently an auditing programme in place to ensure consistency and effectiveness. Part of relevant training modules including Safe Practice Effective Communication (SPEC).*
***January 2019 update. Safewards continues to be the model used by all inpatient areas. The main areas where progress has been made is developing the use of a risk identification tool (DASA), de-escalation training (SPEC), in the last two years 85% of staff have undertaken this national training, the use of community meetings to listen to and respond to feedback and identify expectations of all in a ward environment.***

3. Te Pou, New Zealand's organisation for mental health research and workforce development, recommended that the seclusion and restraint programme known as the 'Six Core Strategies' (National Association of State Mental Health Directors (NASMHPD, 2006) be utilised within New Zealand's Mental Health Services.

*January 2018 update In MHAID reducing restraint and seclusion work has been ongoing using the Six Core Strategies framework.*
*The six core strategies all have leads and bodies of work they are undertaking. Strategies include: Strategy One- Leadership towards organisational change, Strategy Two- Using data to inform practice, Strategy Three- Workforce Development, Strategy Four- Use of seclusion and restraint reduction tools, Strategy Five- Service user/consumer roles in inpatient units, and Strategy Six- Debriefing techniques.*
***January 2019 update. The HQSC reducing restrictive interventions – zero seclusion work has superseded the 6 core strategy framework. It is important to note here that the aim is toward elimination and this is the focus of the work. Some of the key areas being tested at the moment are managing nicotine withdrawal, the use of medication prior to admission, the appropriateness of admitting people who are intoxicated to an acute MH facility. The link between zero seclusion and staff injury is the level of distress/aggression people present with often results in restraint and seclusion and this is the time the majority of staff injuries occur. Staff injury is usually a result of to patient aggression.***

4. There is a positive link between reducing restraint and seclusion and decreasing the number of injuries that occur as a result of patient aggression and during the use of restraint and seclusion.

*January 2018 update. Overall the decreasing trend continues in the use of seclusion however increased periods of seclusion correspond with increased occupancy and overcrowding. All types of incidents increase during these periods including staff injuries. Nationally an issue but locally a bed management project was completed to assist in managing peaks in demand.*
***January 2019 update. The bed management project was completed and despite some good outcomes being implemented there are still sustained periods of bed usage/overcapacity.***

5. A workshop was held in 2014 with multi-disciplinary team members to ensure all were aware of the extent of staff injuries and also to brainstorm what more we could be doing as a service to prevent staff injuries occurring.

*January 2018 update. A health and safety manager was employed in 2016(Glen) who was experienced using a cause and effect methodology which we have referred to as 'Bow tie''. Another workshop was held to identify if there was more we could be doing to prevent staff injuries. A Violence Aggression Action Plan was developed from this workshop which we have steadily been working through. Actions are all nearing completion.*
***January 2019 update. Actions are all compete except the contribution of organisational security services to assist. This now sits with security in their 2019/20 budget considerations. A significant risk for the organisation as not consistent with other hospital sites in Southern or nationally.***

6. A steering group was developed involving unions, occupational health and MHAID leadership to progress themes that emerged from the workshop.

*January 2018 update. On-going – meet 2 monthly, some of the key achievements have been review of all policies, addition of other relevant policies, and development of a resource identifying Personal Protective Equipment (PPE) that could be used, review of alarm systems, agreement with unions that if PPE or alarms are provided they must be used by staff. There are duress alarms in clinical areas and some areas also have cameras in place.*

*Designated parking for shift workers close to building has been put in place. MHAID reception areas were also reviewed following the WINZ incident. A Lone Worker app has been trialled and is progressively being rolled out to staff working in the community. All community based teams have systems in place to account for staff at the end of the working day.*

***January 2019 update. Ongoing – it is invaluable having all multiple perspectives – unions, consumer's families, having oversight and also being part of the problem solving.***

7. The Dynamic Appraisal of Situational Aggression (DASA) is a risk assessment tool that predicts the likelihood of aggression over a very short

time period (24hrs). The DASA tool has been introduced to inpatient units to focus on individualised risk assessment of aggression to others.

*January 2018 update. Implemented in all relevant areas. DASA is a prediction tool – currently we are looking at ways in which this information could be utilised with a preventative focus.*
***January 2019 update. Ongoing as previously described, as more information and research becomes available we are updating our knowledge and training. Risk assessment and management is always changing and developing in line with latest research.***

8. Sensory modulation (assessment and interventions) are established within all inpatient services.

*January 2018 update. On-going, focus now on use of Sensory Modulation in the community setting, i.e. the use of weighted dog in EPS recently helped the person to decrease anxiety about admission as they took the dog with them. A simple but effective intervention.*
***January 2019 update. Ongoing, ED now have sensory packs available to support people to manage their anxiety and distress associated with the assessment process.***

9. There are more assertive interventions prior to someone being admitted to hospital. People will be medicated earlier in the assessment period rather than waiting until someone is admitted to hospital. This action has made a significant impact on the levels of aggression when people are admitted, the need for restraint and seclusion.

*January 2018 update. On-going with constant review to identify new opportunities to intervene early*
***January 2019 update. Still a work in progress. Use of NRT early to support people with nicotine withdrawal is the latest focus.***

10. All staff are trained and revalidated annually in restraint techniques, have de-escalation, and risks assessment and management training.

*January 2018 update. A major area of change. Safe Practice Effective Communication (SPEC) is a national de-escalation programme being rolled out. A significant undertaking - a four day course occurring approximately every two weeks to get all staff within Inpatient and Crisis services through. To date approximately 230 across the district have attended this training. Positive feedback on the theory and skills taught.*

*All MHAID staff undertake orientation and regular mandatory training.*
***January 2019 – ongoing – now BAU***

11. All staff have access to regular professional supervision (not line management supervision).

*January 2018 update. On-going.*
***January 2019 – ongoing***

12. Trauma informed care principles are starting to underpin all education and training provided in the service.

*January 2018 update. On-going – part of all training developed including SPEC*

***January 2019 ongoing within MHAID. Education is being provided to ED and police to ensure a good understanding of the impact of previous trauma to a person's current presentation and strategies to recue distress.***

13. Occupancy levels within inpatient services are monitored daily and beds are seen as districtwide to mitigate risks associated with overcrowded ward environments.

*January 2018 update. Although work is on-going in this area and a bed management report completed this area remains a significant challenge and when demand exceeds resourced beds and staffing resources higher incident rates occur. This is a national issue but locally remedies still being sought. Occupancy of 85% is regarded as best practice to support patient flow in and out of acute mental health inpatient units.*
*Note MH compulsory assessment and treatment legislation means we don't have choices about limiting or delaying admissions to hospital.*
***January 2019 – ongoing – note introduction of afterhours nursing leadership as part of safe staffing.***

14. Restraint practices have changed over the years to ensure best practice for patient care and also to accommodate the imitations that exist because of our aging workforce. A national programme is being developed. Aspects of this programme are informed by the changes southern DHB has made. MHAID are in process of adapting current training to meet national programme requirements.

*January 2018 update. As above when discussing SPEC.*
***January 2019 – ongoing – now BAU***

15. Roster skill mix changes occur as a result of patient demographic changes i.e. changes to Intellectual Disability Legislation. Ward 10a is changing skill mix from untrained to trained Enrolled nurses from 2016/17 budget year.

*January 2018 update. Changes occurring as planned. EN orientation package has been developed across the service to accommodate this group of recently graduated ENs.*

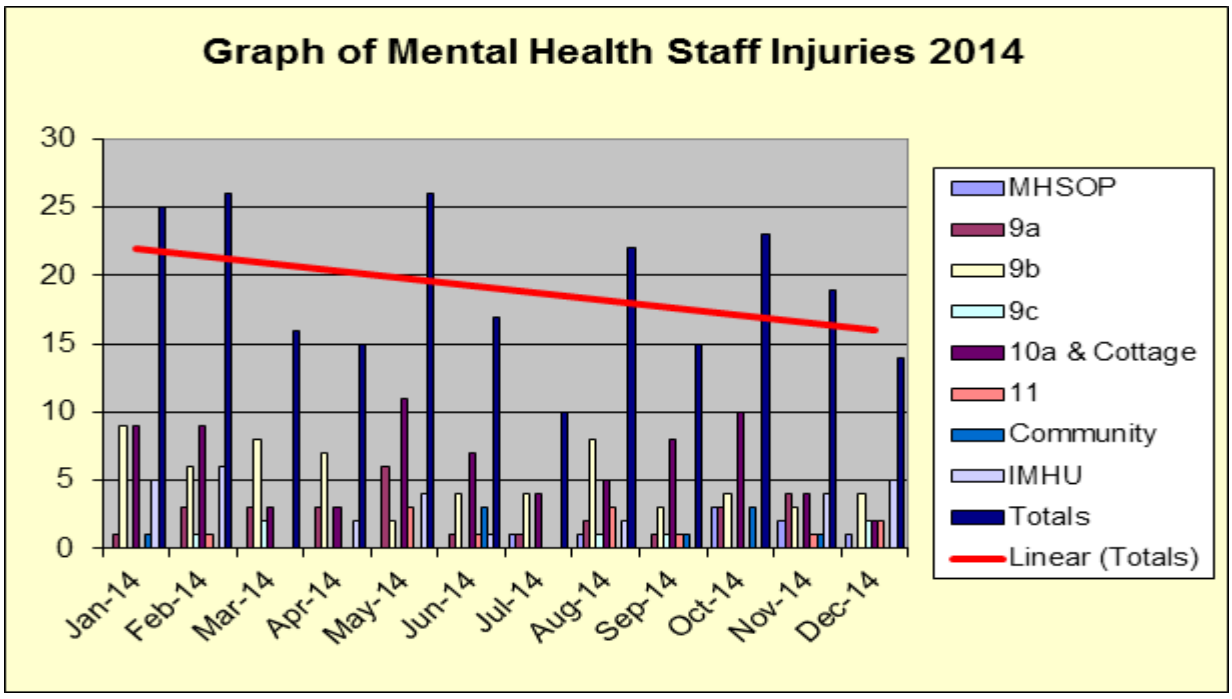
## Data reporting processes.
## Context

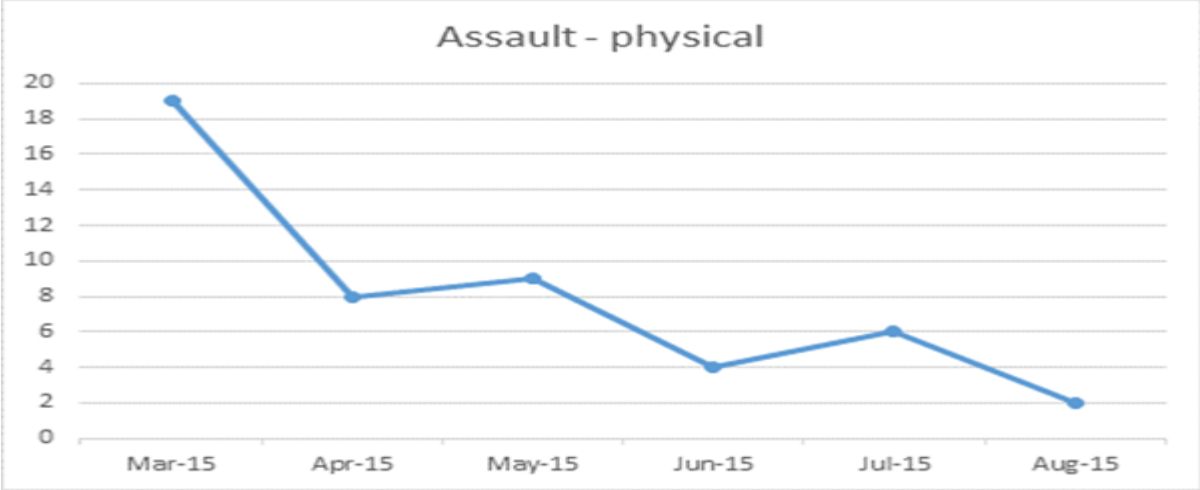
The majority of MH injuries from assault are a result of inpatients actions. The main areas that generate staff injuries are the intellectual disability ward where patients are admitted because of their 'challenging behaviour'. They often don't have language to describe what is happening to them and are sometimes deaf and/or blind and severely intellectually disabled.

The forensic service admit patients because of their mental illness, the combination of mental illness, addictions and criminal behaviours are a challenge to manage in all environments.

Other areas are our intensive care ward (MH) – patients are admitted because they are a high risk to themselves or others and they have acute mental illness. Injuries can occur as a result of attempting to protect the patient from harming themselves or other people.

Reporting processes do not specifically identify injuries due to patient aggression in a clear and consistent manner. The graph below indicates *all* staff injuries were decreasing in 2014 and this was promising however staff continued to be injured.






- Assault can mean – verbal or physical and for the purposes of reporting in the incident system this can range from verbal abuse, spitting, inappropriate behaviour, throwing items, hair pulling, scratching, biting to pushing, and punching plus restraint type injuries.

- Due to requirements all assaults are reported but sometimes no harm comes from them.

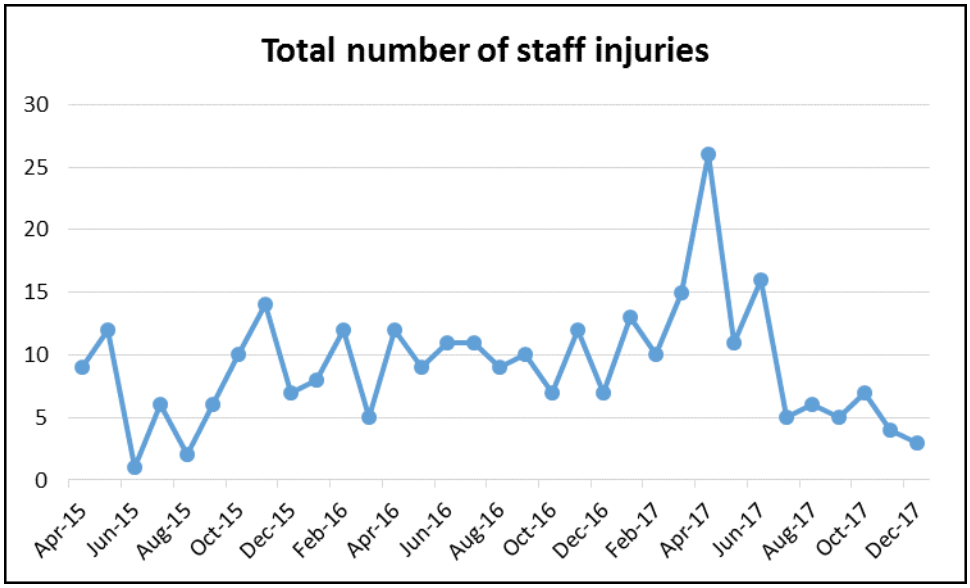
- Some of these incidents involve elderly, who can be often confused or demented in the hospital setting, and intellectually disabled people who have communication difficulties. Therefore this context should be factored into the overall number of assaults.

## Staff events resulting in injuries

The most recent data is an attempt to limit reporting to actual staff injuries caused through patient aggression. Many of the mental health incidents relate to

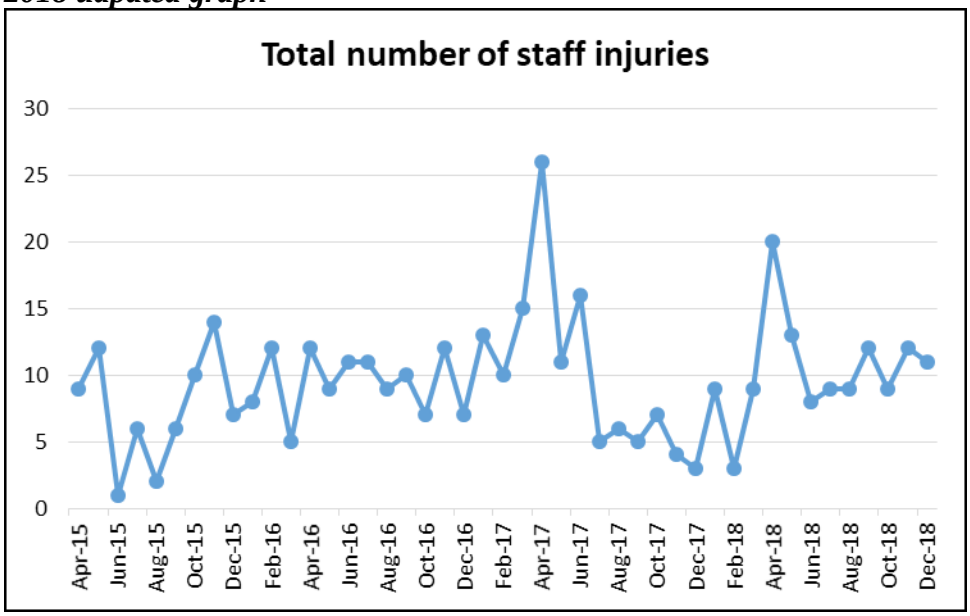
the same patient.  In context, this means that there are a very small proportion of unwell people causing injuries to staff.

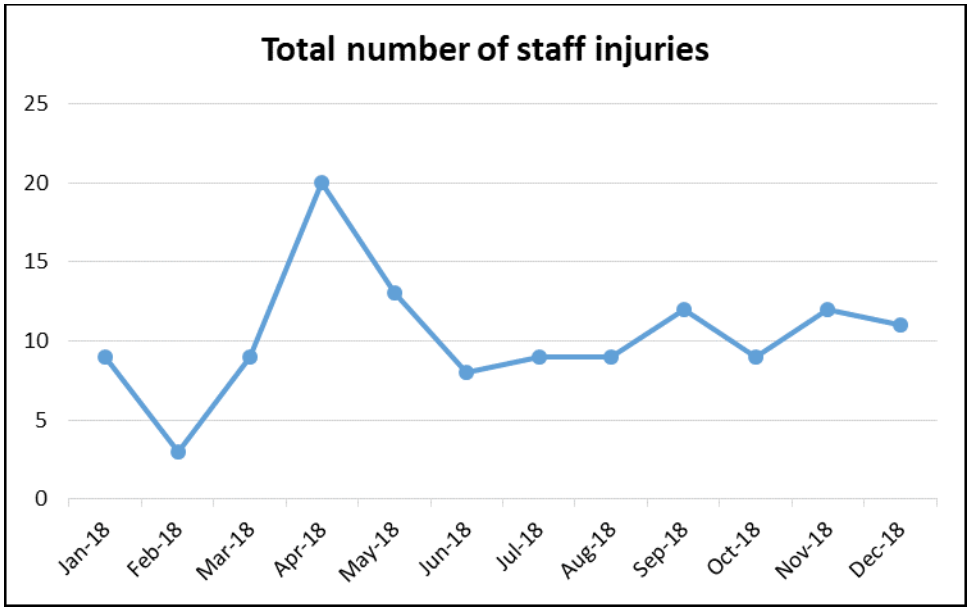
***2015/17***

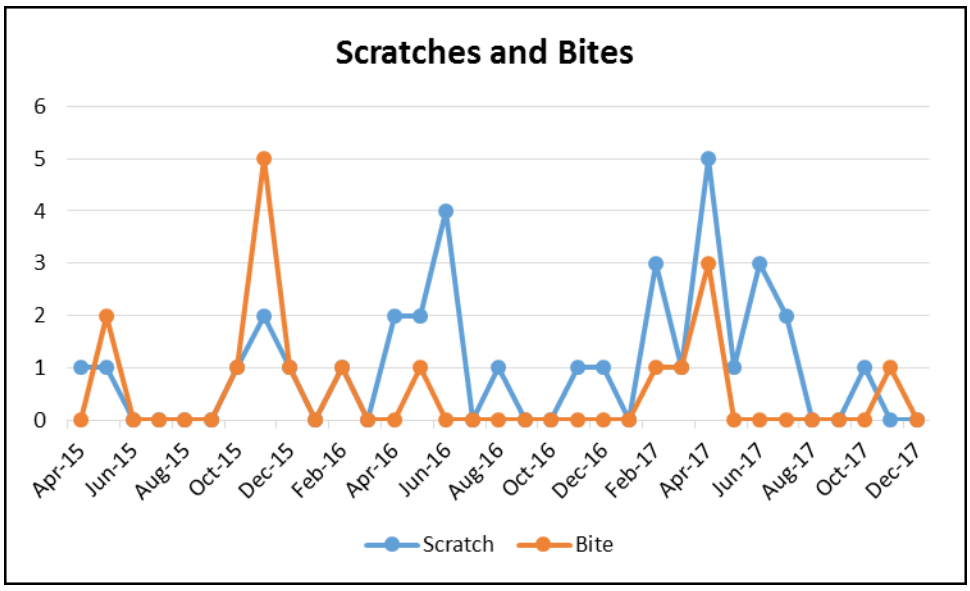



*Note the peak in March to May – this corresponded with sutained period of over occcupancy on the acute/intesive care wards.*

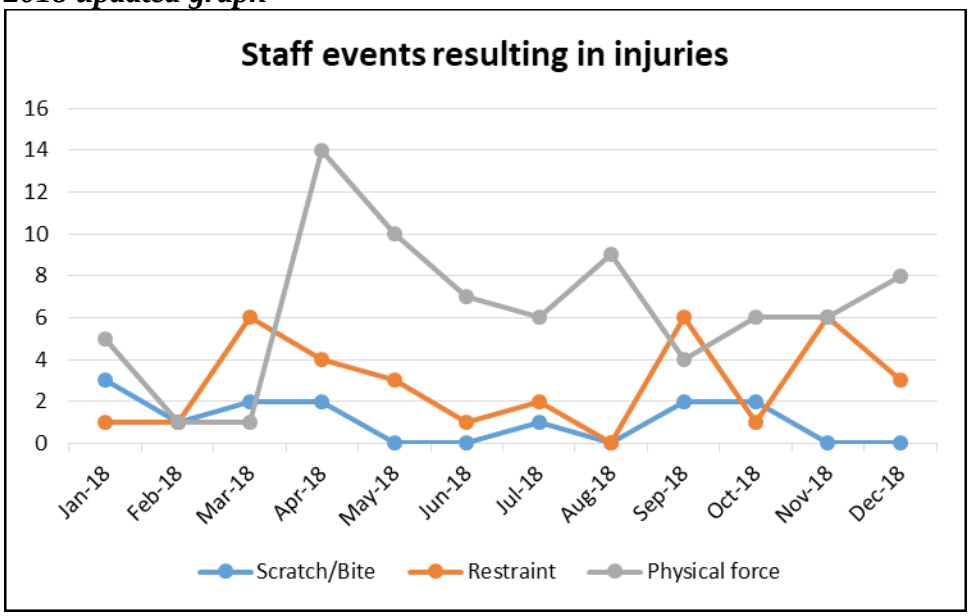
***2018 udpated graph***




Total number of staff injuries
25
20
15
10
5
0
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Scratches and Bites
6
5
4
3
2
1
0
Apr-15
Jun-15
Aug-15
Oct-15
Dec-15
Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
Scratch
Bite

***2018 updated graph***




*Note the maked variation month to month. This is mainly due to individual paitents. Scratching is more likely to occur within Ward 6c, Mental Health Older Persons, during physical cares and bites are more likely to occur within the ID services when epople are acutly distrubed.*

## Summary

Staff injury numbers continue to fluctuate and although in 2014 we were seeing an overall decrease in total injuries the most recent data shows the trend increasing again and significnat variation in number of injuries per month. This is often more to do with individual patients rather than an icreasing level of aggression within services.

The number of staff injury events reported does not provide any detail aorund severity or impact of injuries. Anecdotely although numbers have increased severity and impact have decreased. There is a link in the literature to reducing restraint and seclusion and decreasing numbers of staff injuries.

*January 2018 update*
*Although overall we are seeing a steady decrease the month to month variation is concerning. A recent piece of work looked at the issue of seclusion as an intervention and the relationship to the number of admissions, overcrowding, acuity, and staff injury.*

*There is a positive correlation between the increase in admissions and the flow-on with an increase in occupancy / overcrowding, both steadily rising over the past 3 years.*

*In the context of this, seclusion rates have reduced steadily despite some variability.*

*There is a weak correlation between the peaks in seclusion events and overall acuity, and acuity has certainly increased over the past 3 years in line with occupancy and number of admissions.*

*It is noted that reports of staff injury tend to increase when seclusion events are high. We plan to look at this information in more detail this year.*

*Many of the strategies are ongoing however 2018 will see the following progressed.*

1. *24/7 Security presence at Wakari Hospital and as required within wards to assist with episodes of aggression. A joint paper from MHAID and Building and Property will be presented to the Executive in February recommending and increased presence 24 hours a day, seven days a week on the Wakari site.*
   ***2019 progress. As previously stated. BC for security input is now with security. An additional 4.9 FTE MHAs have been employed for the Wakari site and are currently being orientated.***

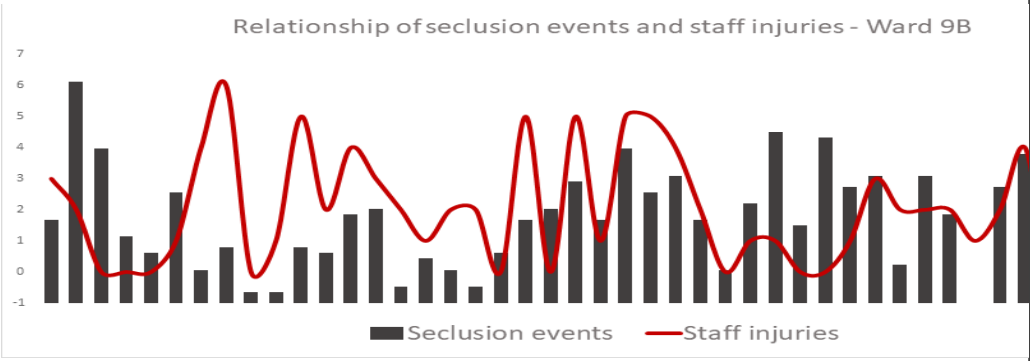
2. *Physical layout of ward 9b will be prioritised as model of care changes are occurring. Alternative spaces need to be available to enable a range of restrictive practices to be reduced.*
   ***2019 progress. Part of wider hospital and MH service redevelopment. Not a quick fix.***

3. *Reducing restraint, the focus to date has been on reducing seclusion and as we make progress with this target we are also focusing on reducing*

*restraint as a number of staff injuries occur during the process of restraining someone.*

4. *HQSC. One of the priority areas for this programme is recusing the use of restraint and seclusion, so new methodology will assist. It is pleasing to see a reduction in seclusion events, and the number of people secluded in context of these challenges. It is noted that reports of staff injury tend increase when seclusion events are high. We plan to look at this information in more detail this year.*

   ***2019 progress***




***January 2019 update***
***Work continues looking at the relationship between staff injuries and use of seclusion. There is not a conclusive correlation but our working hypothesis is that during the process of restraint and placing people within a seclusion facility staff are more likely to receive injuries.***

5. *Staffing – The 2018/19 budget process will include additional staffing is being sought to assist with increased demand.*
   ***2019 progress. The budget process didn't result in additional staffing but the safe staffing agreement in the NZNO MECA did. 6.9 FTE – all but 1.FTE has been used to support inpatient services or sites with inpatient services.***

6. *Bed management is ongoing and 2018 will see roll out of some new initiatives. The organisational restructure will assist as there is now one manager across MHAID system, for example, currently NGOs will not accept people who are incontinent and they remain in inpatient beds. Incontinence is very much a characteristic of our aging population of people with enduring mental illness, so plans are in place to ensure contracts accommodate this need. The subsequent flow of patients through the system will assist with acute inpatient bed management.*
   ***2019 progress. Ongoing, challenges remain, the appointment of 2 people (1 FTE) to undertake the afterhours nursing leadership will assist with bed demand after hours. There roles are part of the safe staffing fTE and have just commenced.***

7. *The area not covered in this report is the support staff receive when they are injured as the focus of this reporting has been what we are doing to prevent staff injuries. This has been another aspect of the work involving the police, ED and developing our own in house model of support (like debriefing but contemporary).*
   ***2019 Progress. ED flow chart to decrease wait times for staff who have been injured is complete. Two recent complaints to police***

***post assault have not result in charges being laid – we are currently addressing these issues with Police. Manners model is being implemented into MH***

8. *We remain very concerned about the condition and layout of the inpatient wards on the Wakari site. These for the most part are original 1990s condition and do not support the delivery of safe (for patients and staff) contemporary acute and sub-acute mental health care. A paper on the current state was submitted to the Executive in late 2017.*

The MHAID Directorate Leadership Team would be happy to meet with the Commissioners to discuss any aspect of this paper.